Testimony of Lucien Wulsin, Insure the Uninsured Project Before the California Performance Review Commission

August 20, 2004

Thank you for the kind invitation to testify before the Commission. I support the Commission's recommendations in items GG 07, GG 26, HHS 01, HHS 02, HHS 16, and HHS 20-33. I would like to address in particular items GG 07, GG 26, HHS 01, HHS 02 and HHS 29, relative to state and county responsibilities for health care to uninsured, low income working adults.

These are Insure the Uninsured Project's thoughts on re-integrating California's MediCal and Healthy Families programs with the county health programs for low income adults and taking the opportunity to increase financing and coverage of low wage working uninsured adults at no new cost to state government through a federal 1115 Medicaid waiver.[1] This approach will improve access to quality care and increase coverage for parents and other working adults, access new federal funding, produce state and local health care savings, consolidate programs and streamline the process of accessing care and coverage for patients, plans and health care providers.

The Commission has recommended a state-county swap of responsibilities in which the state assumes responsibility for health care for low-income uninsured adults from the counties. We recommend that in so doing California seek a federal match for care and coverage to low income working adults through a federal 1115 Medicaid waiver.

Why State Responsibility And Why A Waiver?

Health care costs and insurance premiums have been increasing at three, four, five and six times the rate of worker's wages. This has put enormous financial pressure on all levels of government and on private sector employers and employees.

It is projected by well-respected researchers that absent reforms in coverage and cost containment, the number of uninsured nationally will increase by one third over the next ten years.[2] The growth in the nation's uninsured has been concentrated among low wage working adults both because employment based health coverage has been dropping and because State Child Health Insurance Programs (S-CHIP) have been increasing coverage for children.[3]

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[1] This is a follow up to our earlier letters on MediCal redesign and 1115 waivers dated April 29, 2004 and July 9, 2004, available at www.itup.org.

[2] Custer, W.S., and Ketsche, P. The Changing Sources of Health Insurance, (HIAA December 2000), and Richard Kronick R, and Gilmer T. Explaining The Decline in Health Insurance Coverage, 1979-1995. Health Affairs, 1999; 18(2): 30-47

[3] Holahan, Changes in Employer-Sponsored Insurance 1999-2002 (Urban Institute, 2003), and Kenney and Haley, Children's Insurance Coverage and Service Use Improve (Urban Institute, 2003)

California, Arizona, New Mexico and Texas have high rates of uninsured; Los Angeles County is the epicenter of the nation's uninsured crisis. California alone accounts for roughly 15% of our nation's uninsured. County governments have no capacity to control either the growth in uninsured or the growth in health care costs; only the state and federal governments have the authority and capacity to make the changes needed.

- States have significantly reduced the rate of increase in health costs; California did so with selective contracting, managed care expansions and provider competition reforms in the 1980s and 90s.
- States also reduced their rates and numbers of uninsured; states such as Massachusetts, Minnesota, Oregon, Hawaii, Washington, Arizona and Tennessee have been among the pioneers.

Absent a federal 1115 waiver, federal matching funds are not available for coverage of most low wage working adults that are now the responsibility of California counties.

- Arizona, Oregon, Tennessee, New York, and Massachusetts have requested and received federal Medicaid waivers to cover adults without minor children living at home.[4]
- Utah and Los Angeles County have received narrower Medicaid 1115 waivers to pay for outpatient services to uninsured adults.

California has never applied for a statewide federal 1115 waiver for care and coverage for uninsured adults.[5] California did apply for and did receive a federal waiver that allows us to cover the parents of children enrolled in the Healthy Families program at a 2/1 match; however, at the state level, we lack $100 million in state General Funds to implement this waiver. Meanwhile, we are turning back nearly $1.8 billion in unspent federal S-CHIP allocations[6] to California to the federal government, which then redistributes California's allocations to other states.

An 1115 waiver will require negotiations, trade-offs and consensus among the state and federal and county governments. County governments have a very large investment in county health coverage for adults. Los Angeles County has floated an interesting proposal that is a good starting point for this discussion.[7]

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[4] See ITUP Report on state waivers at www.itup.org click on workgroups; click on Los Angeles.

[5] There were four excellent papers discussing these options prepared by Bob Brownstein, Rick Brown, Helen Halpin Schauffler and Lucien Wulsin and an excellent financial and programmatic analysis by the Lewin Group in the SB 480 State Health Care Options Project. The ITUP paper and Lewin analysis is available at www.itup.org under reports.

[6] We suggest the following priority for unspent S-CHIP funds in the context of a waiver: first for eligible Healthy Families children, then Healthy Families parents, then other uninsured adults.

[7] Los Angeles Federal Waiver Proposal to the MediCal Redesign Workgroup (4/04)

In California, county governments spend over $1.8 billion annually primarily for care to uninsured adults, not now eligible for MediCal, who could be eligible for a federal match with a waiver.[8]

- In many counties, care to the uninsured is financed exclusively with state and county dollars that are eligible for federal matching with a waiver.
- In counties with public hospitals, care to the uninsured is financed with a mix of federal, state and county funding (federal funds cannot be used to match federal Medicaid and S-CHIP funds, but county and local funds can be used as the match).

A waiver of this magnitude will require significant compromises with the federal government and consequential changes in our state's MediCal program. 1115 waivers are subject to a federal budget neutrality cap. California could negotiate an ample cap if the federal government recognizes the historical success of the state's cost containment efforts. Since in California we rank last in expenditures per eligible, the state can logically assert that the federal budget cap should be set at the national average of expenditures per eligible. California can also seek to include its large allocated but unspent federal S-CHIP allocations as part of the cap computations.

MediCal Redesign Should Be Combined With An 1115 Waiver To Cover Adults

MediCal has become the financial foundation of our state's health delivery system. It covers over 6.5 million California residents, costs over $30 billion total and brings more than $15 billion in federal funds into our state.[9] With Healthy Families, it covers more than one in five Californians and accounts for more than 20% of all health spending in the state. It pays for almost two thirds of long term care to seniors in California.[10] It pays for over 40% of all births in the state[11] and, in conjunction with Healthy Families and California Children's Services, about 40% of California's children's care.[12] Absent a waiver, it cannot cover most low income, working uninsured adults.

MediCal is essential to the financial survival of non-profit community clinics, safety net hospitals, children's hospitals, trauma and emergency services, neighborhood pharmacies and providers of long term care services for California's seniors. Compared to other states, California's MediCal program covers a higher percentage of our state's population and provides more services at far lower per person costs.

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[8] Current funding for county health services is inequitable between counties and among the regions; as a result access to care and eligibility for the uninsured county indigent is highly variable between counties. See Perspectives from ITUP's 2001-3 Regional Workgroups at www.itup.org; click on reports.

[9] Governor's Budget Summary 2004-2005.

[10] California HealthCare Foundation. *Medi-Cal Facts and Figures: A Look at California's Medicaid Program*, January 2004, www.chcf.org/topics/medi-cal/index.cfm accessed July 8, 2004.

[11] Managed Risk Medical Insurance Board. *AIM 2002 Fact Book*, January 2002, p.9. www.mrmib.ca.gov

[12] Governor's Budget Summary 2004-2005 and California HealthCare Foundation. *Medi-Cal Facts and Figures: A look at California's Medicaid Program*, January 2004 www.chcf.org/topics/medi-cal/index.cfm accessed July 8, 2004

MediCal, however, does need a thoughtful overhaul for the following reasons:

- The program has largely grown through ad hoc incremental accretions interrupted by periodic budget crisis-driven retrenchments but without a sustained, systemic vision and a lack of serious attention as to how the program interacts with county health systems for uninsured adults. The result is an extremely complex program that adds unnecessary administrative costs and red tape at all levels.
- MediCal fails to cover many of California's working uninsured adults, and we are not taking advantage of opportunities to maximize federal funding as other states already have done, using the waiver process.

Using a Waiver to Maximize Federal Funds For Care to the Uninsured

Expansion of the MediCal and Healthy Families programs is the least costly way for California to cover large numbers of uninsured citizens and legal permanent residents and to pay for emergency, trauma, preventive and primary care services to adults because the federal government would pay half to two thirds of the cost. We recommend using existing unmatched state and local spending on uninsured adults as the match for an 1115 waiver. This can be done at no new costs to state government. A waiver would bring in a 1/1 or 2/1 federal match and could double or in some cases triple existing local spending on the uninsured. A recent report from the Urban Institute confirms half the money needed to cover the uninsured is already in the system, mostly in the form of public dollars.[13]

New Revenues Are Needed For Health Care To The Uninsured

California needs new revenues – a combination of federal revenues, state taxes and/or fees – to solve state and local governments' ongoing structural budget imbalance.[14] The growth in health care costs for low income Californians who lack private coverage are a significant contributor to state and local budget difficulties. Since 1978, California has systematically reduced the levels of state and local taxation through a combination of ballot and legislative measures. This has reduced local government revenues for schools, public safety and health care and increased the demands on the state to support local governments.

California has relied on short term fixes such as the federal Disproportionate Share Hospital (DSH) and SB 1255 funds to shore up local safety net and emergency and trauma networks, but these efforts have hit the wall as federal funds from these sources are capped, constrained and at serious risk. Proposition 99 (Cigarette Tax) Revenues are declining and the portions devoted to county health have declined precipitously.

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[13] Hadley and Holahan, How Much Medical Care Do the Uninsured Use and Who Pays for it? At www.kff.org (Health Affairs June 2003) at www.Healthaffairs.org This does require redistributing existing spending on the uninsured.

[14] See ITUP suggestions at www.itup.org under reports, 2003 and 2004 Budget Report documents.

Realignment funds for county health increase quite slowly, failing to keep pace with health care inflation or the rising numbers of uninsured, low income adults.

Although California has high rates of low income uninsured individuals and families, California does not receive its fair share of federal revenues; we are a net exporter of federal taxes to other states in the country. Many factors contribute to this: we are a young state with a smaller proportion of the nations' elderly eligible for Medicare and Social Services; we are a state of many hard working immigrants who pay federal taxes and yet many of our state's residents are ineligible for federally funded programs, and for over thirty years, unlike states such as New York, California has not systematically maximized its federal Medicaid and more recently S-CHIP revenues.

Changes in Care For Adults Under a Waiver

ITUP has conducted a series of on the ground studies and data reports on care for the uninsured in county health systems, local hospitals and non-profit, free and community clinics in California.[15] In the following sections, we describe how we think eligibility, services, reimbursement, utilization, delivery systems, managed care, cost containment, program administration and DSH funds might change either under a federal waiver or under state take-over of responsibility of care for adults without a waiver. In each of the following sections, we describe how Medicaid (MediCal) works, the difference in county health programs and how this might change with a waiver. We have bolded the changes that we anticipate would occur in the context of a waiver. To briefly summarize, eligibility would expand, and there would be minimum statewide eligibility and benefits in all counties for adults; services would be provided within local managed care systems; utilization of outpatient and other preventive services would double; compensation for uninsured patients would increase, as would patients' choice of providers and program efficiency would markedly improve.

➢ Eligibility for Adults

Federal Medicaid law provides federal matching (1/1 in California) to states for the aged, disabled and families with children. It excludes low income adults with no minor dependent children living at home absent an 1115 waiver.

- About 1.1 million of California's uninsured are adults with incomes below the poverty level. [16]
- About 1.2 million of California's uninsured are adults with incomes between 100% and 200% of poverty. [17]

Federal S-CHIP (State Child Health Insurance Program) provides federal matching (2/1 in California) for states to cover uninsured children with family incomes above the state's Medicaid income limits. It excludes parents absent a federal 1115 waiver (already approved for California).

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[15] See Regional Workgroup reports at www.itup.org.

[16] 2001 California Health Interview Survey. *Ask CHIS.* www.chis.ucla.edu accessed July 8, 2004.

[17] 2001 California Health Interview Survey. *Ask CHIS.* www.chis.ucla.edu accessed July 8, 2004.

- Estimated 200,000 uninsured parents of Healthy Families children have incomes between 100 and 250% of poverty.[18]

California provided coverage for low income adults through MediCal until 1982-3 when under the fiscal pressure of a state budget crisis, responsibility for their care was returned to the counties with funding equal to 70% of state costs. Each county may devise its own eligibility rules to cover adults. Some limit coverage to adults with incomes at or below the federal poverty level while others set income limits up to three times as high. Some care for undocumented adults; others exclude the undocumented while still others limit covered services to emergency only benefits, as MediCal does, for the undocumented.

A federal waiver would likely entail a statewide eligibility minimum, covering parents with incomes of less than 200% of the federal poverty level, adults with incomes of less than 100% of the federal poverty level and undocumented for emergency services consistent with federal law. Counties could be required to maintain existing eligibility and have the options to expand eligibility above the statewide minimums or counties could be released from any responsibility for health care to the indigent under Welfare and Institutions Code §17000.

- Co-premium issues

There has been much recent interest in beneficiary co-premiums as a means to increase program revenues. In Oregon, Washington, Minnesota and Hawaii, research indicated that co-premiums (as distinct from co-payments) are very counter-productive, acting as a major factor in reducing and deterring program enrollment.[19]

- Employer participation issues

There has also been much interest in allowing employers to buy in to the MediCal and Healthy Families programs for low wage workers. Our research indicates there has been modest participation and some state savings with employer buy-ins.[20] The federal government has been very interested in increasing opportunities for employers to voluntarily, financially participate in the costs of coverage in states' 1115 waivers.

➢ **Services**

MediCal covers a wide array of services, including long term care facilities and less costly alternatives to institutional care. MediCal already covers long term care facilities for adults. These services should be preserved.

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[18] Based on Cal-Health proposal discussed in: Lewin Group. *Cost and Coverage Analysis of Nine Proposals to Expand Health Insurance Coverage in California*. (CA HHS, April 2002).

[19] See Mann and Artiga, The Impact of Recent Changes in Health Care Coverage for Low Income People in Oregon (Kaiser Comm. On Medicaid and the Uninsured June 2004) at www.kff.org; and Ku, Leighton & Coughlin, TA *The Use of a Sliding Scale Premiums in Subsidized Insurance Programs*. (The Urban Institute 1997).

[20] Chavira and Wulsin, Premium Subsidies for Low Wage Work Forces (Insure The Uninsured Project June 2004) at www.itup.org. See also Hutchins and Ojeda, Premium Assistance Under SB 2 (California Program on Access to Care May 2004).

Many county health programs cover basic health services, including mental health and prescription drugs. County health programs have limited or no coverage of adult dental care and as a result, dental access for low-income adults is very poor.

A federal waiver would likely entail a statewide minimum set of covered services and pay for basic services to low income adults and emergency only services for undocumented low income adults. It could be the Medicaid minimum package of hospital, physician, diagnostic and laboratory services, and would likely include Medicaid "optional" services such as prescription and mental health services that all counties cover for low income adults.

- Prioritizing basic services

Oregon's used rationing i.e. delineating and deleting coverage for those services with the least medical efficacy as the basis for securing its federal waiver. California should consider a review of covered services to distinguish between the most essential and less essential care and services.

➢ **Reimbursement rates**

MediCal payment rates are typically below payments from commercial insurers. Many providers contend MediCal pays less than their costs of delivering services.

Health care reimbursement rates in county health systems for adults are highly variable, depending on the type of county health system and each county's policy. In ITUP's 2003-4 series of county reports, we reported our calculations of county health payments for inpatient hospital days, emergency room visits and outpatient visits. Our rough calculations are based on counties' MICRS and CMSP reports and in no way represent county reimbursement policies.[21]

- In general, the small CMSP (County Medical Services Program) counties are paying providers at MediCal rates; provider counties appear to be paying at cost, while payor counties pay less.[22]

ITUP Chart of Average County Health Payments for Inpatient and Outpatient Care in Southern California Compared to Statewide Averages[23]

	Provider Counties	Payor Counties in	CMSP	All California

[22] Provider counties refer to counties with a public hospital, payor counties refer to those paying private hospitals and doctors, and CMSP counties refer to those small counties under 300,000 population that opted for state administration. See www.itup.org regional workgroup county-by-county reports.

[23] These are estimates based on county reports to the state and we report them for discussion purposes as the county reports are of varying reliability depending on the county. We calculated these payment rates by dividing expenditures by either days or visits and rounding the result. In provider counties, the physician component is typically included within the inpatient hospital, emergency room or clinic payment, in payor and CMSP counties; physician services are billed and paid separately. In calculating these rates, we used county MICRS and CMSP data and rounded the figures. See www.itup.org county reports.

	in Southern California	Southern California	Counties	Counties
Inpatient days	$2,000 per day	$1,000 per day	$2,000 per day	$2,000 per day
Outpatient visits	$180 per visit	$100 per visit	$60 per visit	$147 per visit
Emergency services	$240 per visit	$140 per visit		$234 per visit

An 1115 waiver would likely require that reimbursement rates for adults be roughly comparable to those in the MediCal program.

- **Utilization**

Utilization of county health services by the uninsured is typically episodic, concentrated in hospital emergency rooms and involves limited use of preventive services. Our rough calculations of inpatient, outpatient and emergency room use rates per county uninsured and per county indigent adult and per insured adult are as follows:

Average Utilization Of Inpatient, Outpatient And Emergency Services[24]

	Inpatient days	Outpatient visits	Emergency services
Insured adult	236 days per 1000 insured	4 visits per insured	154 visits per 1000 insured
County health services per uninsured individual	90 days per 1000 uninsured	1 visit per uninsured	110 visits per 1000 uninsured
County health services per uninsured indigent adult with income below 200% of poverty	180 days per 1000 uninsured	2 visits per uninsured	220 visits per 1000 uninsured

Under a waiver, there would likely be a substantial increase in use of outpatient visits by adults, a potential decrease in emergency room visits and an increase in compensated hospital days for uninsured adults who become insured through the waiver.

[24] In this table for the utilization patterns of insured adults, we are using the Blue Shield Foundation's Essential Benefits Report. In calculating the utilization rates for the uninsured, we used both the county reported data (MICRS and CMSP) and the hospital reported data (OSHPD) and split the reported difference on inpatient days and emergency services and then divided by the numbers of uninsured reported under the California Health Interview Survey. In calculating the utilization rates for the uninsured adults with incomes below 200% of FPL, we used a figure of half of all uninsured. See www.itup.org regional workgroup reports. These utilization rates are rough estimates based on county and hospital reports to the state, and we report them for discussion purposes; the individual county and hospital reports are of varying reliability depending on the accuracy of county and hospital reporting.

➢ **Delivery Systems**

In our county studies, we identified five different types of county health delivery systems: provider counties, payor counties, CMSP counties, private hospital counties and hybrid counties.[25] There is a wide range in the extent of participation by providers in these delivery systems.

- The delivery system in payor and CMSP counties includes the private doctors and hospitals and non-profit community clinics; in some of these counties, such as San Diego, Shasta or Humboldt, community clinics play a leading role in delivering primary care services.
- A provider county's delivery system includes a county hospital(s), county clinics and in Los Angeles, Santa Clara and Alameda, the local non-profit community clinics as well.
- Hybrid counties are structured around public clinics and private hospitals, often excluding non-profit community clinics and private doctors.
- In private hospital counties, funds are concentrated in a single private hospital's delivery system (often the ex-public hospital).

Variations In Provider Participation In County Health Delivery Systems

	Provider counties	**Payor counties**	**CMSP counties**	**Private hospital counties**	**Hybrid counties**
Public hospitals	Yes	No	No	No	No
Private hospitals	No	Yes	Yes	Yes, but limited to one hospital	Yes
County clinics	Yes	No	No	No	Yes
Non-profit community clinics	Yes, in a few counties	Yes	Yes	No	No
Private doctors	No	Yes	Yes	No	No

An 1115 waiver is likely to somewhat widen provider participation in local delivery systems and as a result increase provider choices for previously uninsured patients.

➢ **Managed care**

[25] Provider counties refer to counties with a public hospital, payor counties refer to those paying private hospitals and doctors, and CMSP counties refer to those small counties under 300,000 population that opted for state administration. Private hospital counties refer to counties where the funding is concentrated in a single private hospital, typically the ex-public hospital, and hybrid counties refer to counties with a network of public clinics and private hospitals.

MediCal managed care in many counties increased physician reimbursement and has improved families' access to outpatient and preventive services. County Organized Health Systems (COHS) have improved the coordination and delivery of services to the aged and disabled. Properly applied, managed care can both improve adult patients' access to appropriate care and save system dollars.

County health systems now make limited use of managed care for adults. Based on our research, only Solano (a small CMSP county) and Contra Costa (a provider county) counties currently use managed care to organize their delivery systems for adults. **States with federal waivers rely on mandatory managed care for adults.** Our assessment is that in the context of 1115 waiver negotiations with the federal government, mandatory managed care would be extended to disabled and aged adults as well.

Managed care would entail a significant change in local systems for here-to-fore uninsured adults. As local safety net providers are primarily enrolled in Local Initiatives (LI), specific Geographic Managed Care (GMC) plans and County Organized Health Systems (COHS), **it seems preferable to manage care for newly insured adults through the already existing LI, GMC and COHS systems**.

Families in California's smaller counties are for the most part exempt from mandatory managed care. **California would need to develop mandatory managed care for adults in those regions without mandatory managed care.** In our view, managed care for the less populous regions should not be defined by county boundaries but rather organized by regions. A well-designed regional County Organized Health System could better organize the existing delivery system and improve access to specialty services in rural regions. Federal law caps enrollment in County Organized Health Systems, and an 1115 waiver or change in federal law may be necessary. The other ready alternatives are to contract through MRMIB with the plans participating in the Healthy Families program to cover adults or to pay for care to adults through CMSP and to strengthen that program's ability to manage health costs through selective contracting and care management.

- **Cost containment**

Costs of both public and private health insurance have increased dramatically[26] and cost containment is necessary for public and private sector health coverage. Cost containment in county health is achieved now through frozen funding levels and queuing for services. **Under a waiver, cost containment for county health would be linked to MediCal, as administered through local health plans**. The health plan model would not be particularly effective at controlling emergency and trauma costs of accident victims, but can be effective in controlling costs and improving health outcomes for chronically ill adults who comprise a large share of county health costs.

- **Costs of administration**

[26] Levit et al, Health Spending Rebound Continues in 2002, Health Affairs (January 2004) and California Legislative Analyst's Office, Analysis of the 2004-05 Budget Bill (Feb. 2004) at www.lao.ca.gov

County health program administrative expenses are already low, and in many counties, eligibility determinations are more streamlined and more cost efficient than MediCal; it is imperative that a federal waiver not increase program administrative expenses. One-E-App has the potential to computerize and simplify eligibility as does elimination of the asset test, eliminating duplication between MediCal and Healthy Families, mail-in applications and eliminating repetitive verifications of compliance with eligibility requirements that do not change. There is no reason for the county health, MediCal and Healthy Families bureaucracies to duplicate eligibility functions. **In general, the Healthy Families model of administration is significantly less costly and should be preferred in a waiver; however the entire MediCal eligibility determination needs to be simplified using One-E-App and other computerized systems.**

- **Program simplification**

MediCal eligibility is enormously complex due to 40 years of incremental improvements. County health fills in the program gaps where MediCal excludes coverage and is thus the reverse mirror image of MediCal's complexity. To simplify and rationalize requires a carefully thought out 1115 waiver.

As a starting point, **we suggest that 1) all available income should be counted and treated in the same fashion for all applicants and program eligibles; 2) the asset tests should be discontinued; 3) MediCal coverage for children and adults should extend to 133% of the Federal Poverty Level and Healthy Families coverage applies above that level; the MediCal share of cost program for parents should be dropped and subsumed into the expansion of Healthy Families for parents.** Some of these simplifications require an 1115 waiver while others can be done through state plan amendments.

- **Reform of SB 855 (Disproportionate Share Hospitals) and SB 1255 and Uncompensated Care**

California established its DSH (SB 855) and SB 1255 programs to assist hospitals with the disproportionate burdens of caring for the uninsured in hospital emergency rooms and trauma centers. These programs have evolved over time from their intended purposes; our research found that some hospitals receive large DSH allocations but provide little care to the uninsured; while vital facilities in very poor counties with high proportions of uninsured and low income patients receive little or no DSH funding. Federal regulators are pressing California and other states to demonstrate that there is a qualifying local match and that the federal and local matching funds are serving their intended purposes.

Covering adults through a waiver will significantly reduce uncompensated care to the uninsured in public and private hospitals – we estimate by over 50%[27] -- and that will change hospitals' DSH and SB 1255 allocations significantly. **Accordingly, reform of**

[27] We estimate a very large reduction in hospital bad debt and charity care for several reasons: 1) nearly half of the uninsured can be covered through an expansion, 2) patients are highly motivated to enroll by the size of hospital bills and 3) hospitals are highly skilled and motivated in identifying and enrolling patients.

California's DSH and SB 1255 programs, definitions and matching requirements will need to occur if coverage of adults is a part of the waiver negotiations as we believe it should be.

Thank you for considering our thoughts.

Sincerely,

Lucien Wulsin Jr.
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Insure the Uninsured Project